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ABSTRACT

This guidebook is both a practical tool and a source book to aid health planners assess the importance, extent, and impact of indigenous and private sector medical systems in developing nations. Guidelines are provided for assessment in terms of: use patterns: the meaning and importance to users of various available health services: and ways of combining or integrating indigenous, private, and public health services. The book is presented in four parts. Part I justifies looking beyond public health services to private and indigenous services in a health sector assessment. Part II summarizes current knowledge re: health belief systems around the world, Western-oriented private practitioners, and indigenous practitioners in order to give a sense of the range of beliefs and practices a user of the manual might encounter and how such beliefs and practices may influence program impact. Part III explores the question of social change and the controversy surrounding the integration of various health sectors in a single health program. Part IV describes several methodologies (requiring limited personnel and financial commitments) for assessing non-public health sectors. The guidebook is part of a series intended to assist health sector advisors, administrators, and planners in countries where the Agency for International Development supports health related activities. (Author/SB)

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Guidelines for Analysis of Indigenous and Private Health Care Planning in Developing Countries

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Guidelines for Analysis of Indigenous and Private Health Care Planning

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PREFACE TO THE SERIES

The International Health Planning Methods Series has been developed by the Office of International Health, Public Health Service on request of the Agency for International Development.

The series consists of ten basic volumes which cover a variety of health issues considered vital for effective development planning. These ten volumes are supplemented by six additional works in the International Health Reference Series, which list resource and reference material in the same jubject areas.

The International Health Planning Methods Series is intended to assist health sector advisors, administrators and planners in countries where the Agency for International Development supports health related activities. Each manual attempts to be both a practical tool and a source book within a specialized area of concern. Contributors to these volumes are recognized authorities with many years of experience in specialized fields. Specific methods for collecting information and using it in the palnning process are included in each manual.

The six supporting documents in the International Health Reference Series contain reports of literature surveys and bibliographies in selected subject areas. These are intended for the serious researcher and are less appropriate for broad field distribution.

The volumes in the International Health Planning Methods Series contain the collective effort of dozens of experienced professionals who have contributed knowledge, research and organizational skills. Through this effort, they hope to provide the AID field officer and his host country counterparts with a systematic approach to health planning in developing countries.

PREFACE TO VOLUME SIX

This manual deals with the subject of Indigenous Medicine and Private Health Care in developing countries. It is the sixth volume in a series of works known collectively as the International Health Planning Methods Series.

The series was produced by the Office of International Health as requested by the Agency for International Development to provide AID advisors and national health officials in developing countries with critically needed guidelines for incorporating health planning into national plans for economic development.

Generally, an assessment model for indigenous medicine in undeveloped countries is not available. Health sector analyses performed by donor nations in foreign aid programs also lack methodological consistency. This assessment manual, therefore, is offered as a tool for performing indigenous medicine planning. It provides a conceptual and methodological framework for use by the analyst and policy planner for the development and utilization of indigenous personnel. In this manual, guidelines are provided for assessing the indigenous medical systems and the private sector in health care in terms of:

1. Assessment of use patterns of characteristics of users, circumstances and frequency of use, and types of services used.

2. The quality, quantity, meaning, and importance of various available health services to users.

3. Assessment of ways of combining, integrating, or developing complimentarity between indigenous medicine and the private sector.

The indigenous systems remain enormously important as providers of medical care, not only in the villages, but also in the cities. They contribute substantially to the cumulative impact of health care systems in developing countries. The traditional medical systems serve many needs not being adequately served by Western medicine, in addition to filling the vacuum created by the shortage of Western-trained manpower and the high cost of training. These functions are both psychological and sociological, and they differ somewhat between stable traditional societies and those undergoing the dislocations of rapid urbanization and modernization. They include the following:

1. Relief of stress and anxiety caused by the uncertainties of illness. By treating the "whole personality" and by viewing health as a complex,

ecologically contained phenomenon, with natural, super-natural, ritual and social causation, they operate on the basis of the same cultural premises as their patients and are able to invoke cultural, religious and psychological support to relieve anxiety.

In addition, the medicine men use therapeutic devices which are familiar to the patient, including everday food and drinks, familiar taboos and superstitions, and a common language or dialect. This further reduces anxiety inherent in contact with the unfamiliar world of modern medicine.

2. Cost and convenience. Modern medical care, even when offered free of charge or for a nominal fee by a government clinic, is expensive and inconvenient when we calculate the cost of transportation for a mother with several children or a day's unpaid absence from work.

3. Primary group involvement. Not only do traditional healers manifest a more particularistic, affective and diffuse attitude than do Western medical practitioners (i.e., the former are more personally involved with the patient and tend to treat "the whole person"), but they often involve the entire family as well as the community in the process of diagnosis and treatment.

4. Control of deviance. For the closely-knit traditional community, traditional medicine may constitute an important mechanism of social control, by diagnosing the cause of disease or ill-fortune and by prescribing corrective measures.

   Unlike Western medicine, which asks, "How did I get sick?," traditional medicine asks "Why did I and not my neighbor get sick?" It ultimately provides a satisfying answer couched in terms of some super-human system of retribution and justice.

5. Additional functions of traditional healers in transitional societies are served by healers serving recent urban migrants in the teeming cities of developing countries. These functions include the following:

   a. Minimizing the trauma of cultural change; the traditional healer as "culture broker." Traditional healers help to maintain the personality integration of the rural migrant in a baffling urban milieu by interpreting illness in familiar terms and by exhibiting familiar behavioral, linguistic and attitudinal patterns. At the same time, the urban folk healer often incorporates scientific terminology into older magical thought patterns, prescribes antibiotics, and refers difficult cases to a government hospital or clinic.

   b. Alleviating personal stress resulting from social disorganization, uprooting, and anomie. In cities wider economic opportunities combine with the attenuation of ascribed status and with increased social mobility to raise the aspirational level of recent rural migrants. Inadequately prepared and disadvantageously located, however, migrants commonly fail to attain their aspirations.

c. Fostering ethnic identity. In ethnically heterogenous cities traditional medicine provides a focus for group identity by distinguishing between ingroup members and nonmembers. It thus supplements other aspects of the group's culture such as religious and ethnic rituals.

When we consider the diverse functions of traditional medicine in rural as well as in urban societies, as discussed above, it is not surprising that it has survived in spite of the increasingly successful onslaughts of modern medicine.

An earlier version of this volume was prepared for the Office of International Health by the Stanford Research Institute as subcontractor to E.H. White & Co., Management Consultants, San Francisco, California. This manual was prepared by Dr. Susan Scrimshaw of UCLA School of Public Health. She added a number of chapters to the earlier volume, and revised the portions written earlier.

The contributors to this manual have frequently expressed personal points of view with reference to specific indigenous health practices. While their viewpoints generally coincide with organizations or agencies with whom they are associated, the material in this text should not be construed to reflect the official policy of any agency or organization. It should be emphasized that the present work makes no claim to being comprehensive in the field of indigenous medicine. Constraints of time and funding have made a degree of selection, and regrettable omission, unavoidable.

Special thanks are due to Dr. Rene White Fraser and Elye Pitts, whose inputs to this volume were invaluable. The contributions of Dr. Barbara Pillsbury of USAID, Dr. George Coelho and Dr. Bella Maday of NIMH, Ms. Toby Newman of Northern Virginia Mental Health Institute, Dr. Aliza Kolker of George Mason University, and Dr. Lucy Cohen of Catholic University are recognized for their review of manuscripts and helpful advice to the project officer on various phases of this project.

Paul Ahmed

Paul I. Ahmed
Project Officer
Office of International Health
and Series Editor
International Health Planning
Methods Series

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CHAPTER I. INTRODUCTION

A. Purpose of This Manual

This manual is intended to assist health planners to assess the importance, extent and impact of health care provided outside of the public sector in developing countries. This includes individual and familial health care, indigenous practitioners, and individuals trained in the Western medical tradition who are in private practice. Guidelines are provided for assessing the indigenous medical systems and the private sector in health care in terms of:

1. Assessment of use patterns by characteristics of users, circumstances and frequency of use, and types of services used.
2. The meaning and importance of various available health services to users.
3. Assessment of ways of combining, integrating, or developing complimentarity between indigenous medicine, the private sector, and publically financed and administered health service.

B. Format of the Manual

The remainder of section I describes the justification for looking beyond publically administered health services when conducting a health sector assessment. It examines problems in the application of Western medicine, cross-cultural variations in perceptions of health and illness, and the importance of private Western oriented and indigenous practitioners. Section II of this manual is entitled "Health Seeking Behavior." It summarizes our knowledge on health belief systems around the world, on indigenous health practitioners, and on Western-oriented private practitioners. It also discusses health decision-making patterns and health services utilization patterns which exist in various forms in different cultures. It is intended to give a sense of the potential range of beliefs and practices which a user of this manual could encounter, and how these beliefs and practices may influence program impact.

Chapter III discusses the question of social or cultural change in general, and the controversy surrounding the integration of public, Western oriented private, and indigenous health sectors in the planning in a single health program. The issues and the solutions will vary from country to country, so the diverse arguments are explored in some detail.

Chapter IV provides various methodologies for the assessment of the private and indigenous health sectors. These are mainly geared to what can be done by a few people with few resources, although the possibility of large scale research is also discussed.

C. Problems in the Application of Western Medicine

"Large numbers of the world's people, perhaps more than half, have no access to health care at all, and for many of the rest, the care they receive does not answer the problems they have." (Bryant 1969) Despite the fact that the technology exists to solve many, if not most, of the world's health problems, this statement was essentially accurate in 1969 and remains so ten years

later. Reasons for this include factors such as poverty, educational levels, national resources, standards of living and many others which are beyond the scope of this manual. However, the relationship between poverty and ill health is neither inevitable nor universal.

One reason for the failure of Western medicine to benefit the entire world is that it has often been introduced with the assumption that if you have a technological solution to a problem, people will use it. In fact, technology is often rejected or misapplied for a variety of reasons. Two of these were described in an article entitled "Health Action in Cross-Cultural Perspective." "The fallacy of the empty vessel is the assumption that nothing exists in the way of health beliefs and behavior until the arrival of Western medicine, which is then gratefully received." The "fallacy of the separate capsule" acknowledges that indigenous health beliefs and practices exist, but states that they are not comparable to Western professional health practices, and are therefore not viable as professional alternatives (Polgar 1963). As will be demonstrated later on in this manual, not only do indigenous beliefs and practioners exists in nearly all societies, they perform many useful functions.

D. Variations of Health and Illness

Another reason it is important to examine indigenous medical beliefs and systems is that there are cross-cultural differences in the approaches to the definitions of health and illness. As a result, people from different cultures declare themselves ill (or are declared ill) at different points in a continuum which ranges from no symptoms to very severe symptoms. This leads to differences in the timing of resort to health practitioners.

The terms "indigenous" and Western" as used here have been deliberately and carefully chosen. "Indigenous" refers to non-Western medical practitioners and systems, in accordance with the connotation "of the culture" or "within the culture." Terms like "primitive," "native," and "traditional" have been rejected, because they frequently are used pejoratively to mean "not as good"--usually in comparison to Western culture. Of course any new label may in time and with use take on the negative connotations of old labels if the structure of the relationship between those who use it and its denotation does not change. There is some evidence that this relationship is beginning to change: there is no scientific or practical basis for assuming that Western medicine is appropriate all of the time, a fact that is acknowledged by many of its practitioners. Western medicine has more efficient techniques for solving some kinds of health problems than others. For examples, medical problems related to stress may respond better to indigenous treatment which supplies social and emotional support to the patient. While Western medicine might also be described as "indigenous" to Western culture, the distinction between the two terms seems clear enough when they are used together. "Western" was chosen instead of "modern" because of the many modern aspects of medical systems outside the Western one, which in turn is characterized by some very ancient principles and practices.

In fact, no single system can be described a "Western" medicine, which is largely derived from both European and American practices. Moreover, only relatively recently (the past 50 years) has this medicine had a formal "scientific" basis in that it has been able to systematically understand many

diseases and produce what Dubos calls "the magic bullets of medicine," e.g., antibiotics and other "wonder drugs" (Dubos 1959, Rosenfield 1977). In a short period of time, Western medicine has come to dominate many of the responses to health and illness throughout the world (Dubos 1959). Because of this domination, there is a tendency to forget that Western medicine developed in the context of Western culture, which places a great importance on science in contrast to social stability, family relationships, and individual psychosocial needs. The cultural orientation toward the scientific influences its perception of disease. "Disease" is what physicians and biologists define and study. The whole medical complex in Western nations including knowledge, practices, organization, and social roles can be termed "biomedicine" (Fabrega 1975). This cultural ideal persists in the face of the reality recognized by every practitioner that medicine still has a great "seat of the pants" or art component.

One example of this is that radical mastectomies were performed for many years before any careful epidemiological research emerged to show that less drastic techniques were equally effective in most cases. The bulk of standard Western medical practice has not been developed or even validated scientifically, but has arisen out of an immediate need situation--someone's informed impression or interested hunch. Medical training involves an apprenticeship where skills and information are passed from one individual to the other, on the basis of what has worked for the senior practitioner as well as on scientific evidence when it exists. Later, information is shared informally and anecdotally among colleagues. For example, obstetrical residents were overheard in a heated discussion over which kind of stitch to use to repair a vaginal tear after childbirth, but no one was able to cite any research on the topic. All were arguing on an experiential basis. Notwithstanding, biomedicine has difficulty in recognizing, and treating, what it cannot measure "scientifically," even though what it can and does measure is continually expanding. A few years ago, nausea in pregnancy was considered a psychosomatic problem, and was interpreted as a woman's poor psychological adjustment or subconscious rejection of her unborn child. Recently, biomedical researchers have learned that such nausea correlates with higher retention of the pregnancy. Now that science can measure hormonal changes and associate them with morning sickness, it is seen as positive occurrence (the pregnancy is "taking well") rather than a psychological problem on the woman's part.

In contrast to Western biomedicine, most indigenous medical systems do not make the sharp distinction between measurable deviance from expected biological functioning, and not feeling well. Indigenous medicine often defines illness (as distinct from disease) in the social sense, as interference with normal social behavior and the ability of the individual to function. Thus the definition of illness is more encompassing, or holistic, than disease, which represents merely changes that can be measured within a narrow biophysical framework. Interestingly enough, the official United Nations definition of health, which describes health as a state of physical, mental, and social well-being and not merely the absence of illness, mirrors this definition common to so many indigenous medical systems.

Indigenous medicine also differs from Western biomedicine in that the possible causes of the disease may include problems or imbalances in the supernatural realm, body imbalances, strong emotions, and the like. Beliefs about illness causation often form effective social controls when illness is the supposed

outcome of deviant behavior. Frequently illness, health maintenance, religion, and social relations are intimately interwoven.
Indisputably, Western biomedicine has made major contributions to world health, and many of its techniques are life-saving. There are, however, problems that it has failed to solve--because it has not recognized them as problems or considers them low priority (such as many aspects of preventive care), or because they are defined and diagnosed by another cultural system. If, for example, the indigenous system recognizes certain symptom constellations as defining an illness that is not recognized by the Western system, the Western-trained practitioners may discount them as mere "superstitions." Illness, health maintenance, religion, and social relations may be intimately interwoven in any culture. Whereas this is as true for "Western" culture as it is for others. Western "scientific" medicine often ignores this most important reality. The fact is, indigenous medical beliefs and practices that are ignored by Western practitioners play important roles in the control of social deviance and continual search for social equilibrium. Inappropriate behavior, such as transgression of sexual norms, (adultery) or social norms (being rude to one's elders) may be punished by illness (through the work of deity or of a human with special powers). Appropriate behavior is seen as a preventive measure, but if illness occurs in any case, then it might have been worse without the good behavior. In other relationships between illness and social equilibrium, illness permits an outlet for frustration or eccentricity. For example, women in Latin America are seen as being more susceptible to "nerves." When this condition is diagnosed, the subsequent attention may go far to relieve the stresses which forced the woman to manifest the symptoms of withdrawal, depression, and lack of appetite. Within its own setting Western medicine also has social control functions, and the norms that it upholds are Western middle and upper class, primarily Anglo norms. For example, in the U.S., both the patient and the practitioner often blame the patient for an illness. Tension, overwork, poor eating habits and lack of exercise are all among behaviors which are attributed to many illnesses, some with a scientific basis, some not. The individual who behaves according to all these norms is seen as warding off illness. In a sense, then, a Western-trained practicitioner working in a non-Western setting is dealing with a conflict or norms. Beliefs about human behavior that are implicit in his approach to medicine are not a part of the reality of the patient population. The result is a dissonant situation in which the Western practitioner attempts, on the basis of his or her expectations, to make the patient conform to a health belief system that the patient does not share.

E. Western and Indigenous Practices

All this complicated by the fact that scientific knowledge is only a part of Western medicine. It is of little use in itself as separate from the people whose health it aims to improve. The biomedicial system can be said to include practices, organizations, and social roles in addition to knowledge. Knowledge, then, is applied to the individual through a delivery system that could hardly be described as value free. As the science is translated into the art of medicine, many of the cultural values of its practitioners are incorporated into the delivery of health care. Individuals from diverse cultures trained as Western practitioners cannot help but absorb some of the accompanying values, which may inhibit their perception of some of the realities and needs of the non-Western population they serve. In addition,

practitioners are often members of the upper socioeconomic strata and dominant ethnic group in their area of operation. Because of these differences, numerous points exist where the beliefs and needs of the patient population and those of the Western-oriented practitioners fail to coincide.

Not surprisingly, private practitioners have a strong incentive to be in tune with existing indigenous beliefs and practices since their livelihood depends on a satisfied clientele. Public sector programs do not always have this incentive, which is sometimes reflected in a lack of response cultural and individual expectations. Thus, both the Western-oriented private and indigenous sectors may provide important alternative sources of health care.

F. Problems in the Delivery of Western Health Services

Another major reason for assessing the indigenous and private health sectors is that the public sector may have difficulty in reaching all the population of country. Many developing countries have large rural areas which are not easily accessible, and where many Western type practitioners (doctors, nurses trained nurse midwives, dentists) are not comfortable living because the standards of living, educational system, and other similar factors cannot compete with those in urban areas. As a result, public sector health care is sometimes set up with a referral system. However, this system depends on two scarce resources: rapid and affordable transportation, and time to invest in obtaining health care. The distribution of Western practitioners, who are concentrated in the urban areas, combined with the inefficiency of transportation, means that rural patients must invest a great deal of time to obtain modern health care. The shortage of money, which results in few and often understaffed clinics, has the same effect. There has been a myth in international health planning that,

> ....the poorer the person and the greater his need, the more time he will have available to wait in clinics, bring children to health centers, make repeated visits, or attend lectures and demonstrations (N.S. Scrimshaw, 1974:).

In fact, the opposite is true. This has been responsible for many failures in progams of modern health care. For instance, in a village in South India, most women are forced by economic necessity to work up to the eighth or ninth month of pregnancy; they "are too busy to be able to come once a week and spend half a day or more waiting in the clinic" (Djurfeldt and Lindberg, 1975:209). In Peru, a lack of time on the part of some housewives interacted with cultural factors to prevent adoption of water boiling, a seemingly simple preventive health measure (Wellin, 1955:86-90).

Modern physicians and government spending for health care are concentrated in the urban areas in the less-industrialized countries (Spiro 1967:148) (Sharpston 1976:26). This concentration is partly due to political factors. Many of the physicians are employed in large, well-equipped hospitals. These urban hospitals are built for several reasons. One is identifiability. Identifiability refers to the extent to which an effect can be ascribed to a particular decision-maker. It is politically expedient that improvements in health be highly identifiable. For many of the pervasive health problems in developing countries--malaria, diarrheal diseases, and trachoma, for example--the most effective approach might be a preventive one. But preventive methods

have a very low identifiability. Curative methods have much higher identifiability and will therefore be preferred by political decision-makers (Raiffa et al., 1977:73). Another reason is the fact that Western countries often provide money for health care, and in addition to the desire for identifiability, the donors often have the Western orientation toward curative health care and medical technology. A third reason is the relatively great political and economic influences of the high socioeconomic groups. These largely urban groups are much more important in determining health care priorities than their needs warrant. Their health problems resemble those characteristic of the developed countries, being mostly the "chronic and degenerative diseases typical of later life," such as heart disease and cancer (Sharpston, 1976:26). These diseases are generally treated by curative methods involving a high degree of medical technology.

All these influences, which also operate in the industrial nations, tend to produce curative high-technology medicine centered in the urban areas. It has been argued that these forms of health care "have frequently served to dissipate scarce local resources and skilled manpower, and were of no general benefit to the countries" (McMichael, 1976:7). While this is putting it strongly, certainly more equitable distribution of facilities and physicians, and perhaps are greater emphasis on prevention, would be more effective in raising the general level of health.

Private and indigenous practitioners can be an important part of this effort. Although it is difficult to estimate the relative use of private and public health care, a study of the allocation of resources for health care in Peru estimates the monies spent on health care are evenly divided between public and private resources. The private payments represent payment by rural and urban poor to traditional healers and those paid by the wealthy (5 to 10 percent of the population) for the resources of the private medical sector. In addition, Lima, the principal urban center, and the surrounding areas, contain about 20 percent of the national population and 65 percent of all the physicians (Roemer 1977:217-219). Although major categories of graduating health profesionals in Peru are legally obligated to work in medically underserved communities for periods of up to one year after their graduation, few stay in such areas after their required term of service.

G. Summary

To summarize, the major reasons for including the indigenous and private health sectors in the health sector assessment of a country are that:

1. The population has deeply ingrained and functional health beliefs and behaviors which must be considered and accomodated when Western medical technology is introduced.
2. Because of differing definitions of health and illness and the treatment of illness the Western medical system may not supply all the medical needs of a population as defined by both that population and modern health planners.
3. Minimally accessible rural populations with poor infrastructures are not suited for highly trained practitioners with Western medical values, and for health service delivery systems designed for urban of Western settings.

CHAPTER II, HEALTH SEEKING BEHAVIOR

A. Overview of Indigenous Health Related Belief Systems*

A medical system is seen as "embracing all of the health promoting beliefs and actions and scientific knowledge and skills of the members of the group that subscribe to the system" (Foster and Anderson 1978:36). Medical systems can be broken down into two subsystems for the purpose of analysis:

1. A disease theory system, which "embraces beliefs about the nature of health, the causes of illness, and the remedies and other curing techniques..."(Foster and Anderson 1978-:37). It is a conceptual system which deals with classifications, explanation, and cause and effect.
2. A health care system, which is the way a society mobilizes the resources of the patient, his or her family, and the society to bring them to bear on the problem (Foster and Anderson 1978:37). It involves the interaction of two people, the patient and the curer.

This distinction is particularly useful in situations where more than one medical system exists, as is the case in most developing countries. When this distinction is made, it is possible, for example, to allow people to retain elements of an indigenous disease theory system while adding a Westernized component to their health care system.

Universal Aspects of Medical Systems

Some universal aspects medical systems are described below.**

1. Medical Systems are integral parts of culture: The major institutions in every culture are related to each other and support each other. For example, in many cultures disease beliefs are an integral part of religion and/or magic. In many parts of the world displeasing a supreme deity (God) is thought to bring about illness, and the deity's help is sought in the curing process (prayer). In addition, social institutions are reflected in the roles of curers and their relations to patients. For example, in many Latin American communities the midwife must be an older women, who cannot be criticized for being out late at night as would happen with a younger woman.

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* This section of this manual draws on the literature review done by Plog Inc. on the "Sociocultural Factors that Affect Health Care Delivery in Developing Countries." The users of this manual may wish to refer to that literature review for more detail, and to the manual entitled "Sociocultural Factors in the Assessment and Planning of Health Care Delivery Systems in Developing Countries." (International Health Planning Methods Series, Vol. 4, Office of International Health,

** These are based on discussions by Foster and Anderson (1978:39-47).

2. Illness and Health are culturally defined: As discussed in the sector of I-C of this manual, illness is defined differently in different cultures. The same set of symptoms may be viewed as a health problem in one setting and as normal in another. One example of this is worms (ascaris) in children. In many parts of the world, it is assumed that all children have worms. In Latin America, it is believed that children get worms from candy. In another instance, parts of Africa where schistosomiasis, a parasite which invades blood vessels in the bladder area (in other religions the parasite has adapted to other sites within the body) is common, blood in the urine of men is not considered abnormal, but is referred to as "male menstruation." (See the manual on Sociocultural Factors for additional details on this subject).
3. All medical systems have preventive and curative sides: Prevention may range from a red bracelet on a child to ward off the evil eye to a smallpox vaccination, but the concept is there in most cases. However, the Western medical system relies heavily on the institutional and governmental measures, such as a potably water system, as well as individual measures. Although other systems such as the Chinese (in both ancient and modern times) have had institutionally based health care, in many societies "preventive medicine consists of personal acts rather than legal functions, personal behavior that follows logically from disease causation concepts which, by explaining why a person falls ill, simultaneously teach what must be done to avoid illness (Foster and Anderson 1978:41). If illness can be caused by an envious neighbor resorting to witchcraft, then it is best to conceal your assets from your neighbors, or to share your wealth through donations to religious festivals and similar community activities.
4. Medical systems have multiple functions: Because medical systems have usually developed within a specific culture, they often serve a number of functions in that society besides the obvious one.

   a. A disease theory system provides a rationale for treatment: If a Haitian healer says an illness is due to the neglect of an ancestor's property, you fix up the property. If a blood test shows anemia, iron is administered.
   b. A disease theory system explains "why": In most societies patients are concerned with why they fell ill, and how to prevent future illnesses. Disease causality systems provide an explanation.
   c. Disease theory systems often play a powerful role in sanctioning and supporting social and moral cultural norms: In many societies, including in the Judeo-Christian tradition, illness has been explained as punishment for sin or wrong-doing. Repentance and appropriate behavior are needed to end the illness and prevent future recurrences.
   d. A disease theory system may provide the rationale for conversation practices: In many cultures, the world is seen as being in a balance and the healer works to restore the balance. In one Mexican Indian group a hunter who killed too many deer was punished with the loss of his soul (Foster and Anderson 1978:45).
   e. A disease theory may serve to control aggression: Sex differences in the instances of "susto" (magical fright leading to illness) in a Mexican village reveal that susto is much more frequent among women, who have fewer emotional outlets than the men. Women have a tighter set of role expectations and fewer ways of relieving anxiety than do men in this society. By getting susto, women are relieved of some of their

responsibilities for a time, and get more attention, thus reducing tension (O'Nell and Selby 1968).

f. The nationalistic role of indigenous medicine: Just as the Western world is proud of its medical achievements, many other nations have justifiable pride in a rich medical system. Among the more important non-Western medical systems are ancient and modern Chinese medicine, Hindu, Ayurvedic, and Moslem Unani Tibbi medical systems.

Ethnomedicine (Indigenous Medical Systems) and Beliefs About Disease Causation

The process of understanding disease systems within societies is called ethnomedicine by anthropologists. Anthropologists make a distinction between the system as viewed from the perspective of the culture and the system as viewed from the outside. The word emic is used to describe the insider's, the word etic the outsider's. For example, an emic explanation for post-partum infection may be that cold entered the uterus during childbirth. An etic explanation is that harmful germs entered the uterus during or soon after childbirth. If the insider and the outsider could agree on preventive measures, the different beliefs about causation would not matter. What follows is a list of types of emic views of health and illness from around the world. It is unlikely that any one medical system would incorporate all the types.

1. Body image: Perceptions of ideal height, weight, and other physical aspects vary with the society and may affect nutritional and other health related behavior. For example, a plump baby is seen as ideal in many cultures, but the edema of kwashiorkor, a severe malnutrition/infection syndrome in young children, may be mistaken for healthy plumpness, thus delaying treatment preventing parents from acknowledging a problem exists.
2. Definitions of Health: These have already been discussed as they vary from one culture to the next, but they may also vary by age and sex within a culture.
3. Definitions of illness: These also can vary by age and sex. Faintness may be defined as illness in a woman and go unmentioned by a man because is is a "feminine" problem.
4. Illness causation beliefs:

   a. Soul loss: Often caused by a fright or shock (such as the death of a loved one) the symptoms of soul loss include wasting away, fever, diarrhea, sleeplessness, listlessness, headaches. It often describes illnesses which in etic terms include tuberculosis and infant malnutrition.
   b. Spirit possession: This is widely distributed, from the Philippines to India to Africa. The spirits may be deities, ancestors, dead friends or relatives, or other beings with various origins and properties. Frequently they make the individuals possessed behave in socially unacceptable ways. In some cases this serves as an outlet for tension in the individual. In other cases diseases considered serious by Western medicine are attributed to spirit possession.
   c. Evil eye: Wittingly or unwittingly, the gaze of another, particularly someone with light eyes, can induce disease. This is very widespread belief. Young children are considered the most susceptible.

d. Violation of taboos: These can range from offending spirits, ancestors, deities of all sorts, to violating social norms or sacred areas.

e. Bewitching (Sorcery): In some societies only a few individuals are capable of causing illness, in others nearly everyone knows a few spells. Sorcery is especially prevalent in Africa and in areas where people of African descent live.

f. Intrusion of a disease object: Sometimes this is done by a sorcerer, but sometimes you can just "pick up" a harmful substance.

g. Disturbed emotional states: These include envy, "nerves", sorrow, anxiety, heavyness of the heart, and many others. Symptoms are listlessness, depression, loss of appetite and wasting away.

h. Volitional airs or winds: Many areas in the world have winds that come up at certain times of the day or time of the year. These are said to bring changes which are detrimental to health. An example are the Santa Ana winds in the Los Angeles area, which are often blamed for colds and other illnessess by residents of the area. Air can also cause illness in some belief systems, either by entering the body or bringing malaise. The night air is particularly suspect.

i. Contamination by unclean persons: This can occur by means of the gaze (evil eye), from a person's touch, or even a person's presence. In addition to persons with specific illnesses, women who are menstruating are often considered unclean and dangerous, as is menstrual blood. Similarly, pregnant women may be dangerous because their gaze is too powerful or too "hot" and can induce illness and harm crops.

j. Body balances (Humoral theories): These probably originated in India, and spread from there to Greece, where they were incorporated in Hippocrate's work and disseminated throughout the Western world. They are one of the commonest disease causation belief systems throughout the world. The details vary from one culture to the next, but the underlying principle is that certain elements (from two to nearly a dozen in some systems) are balanced within the body and the disruption of such balances can cause illness. Although some systems get very complex, particularly in Asia, two of the most common elements are hot and cold., For example, all food may be classified as hot or cold regardless of actual temperature, and a proper balance of hot and cold foods must be eaten in order to maintain health. Illnesses may also be classified as hot and cold, and the appropriate treatment must take this into consideration.*

k. Blood beliefs: These may be closely related to the body balances described above. Blood may be too hot, too cold, too fast, too slow, too thick, too thin, too sweet, too salty, too high or too low (Haiti). In some areas, such as Central America, blood is believed to be nonregenerative so any blood lost is assumed irreplaceable. This makes it difficult to get blood samples for testing.

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* Michael Logan offers an excellent discussion on the effect of hot and cold beliefs on the acceptance of Western-oriented and indigenous treatment in Latin America (1978).

i. Dislocations and Obstructions: Various organs of the body may be dislocated or obstructed according to this system. For example, in Mexico, a skimpy menstrual period may mean blood has gone to the lungs and will obstruct them. This makes the oral pill less acceptable as a form of contraception in this society).

The beliefs described above are among the more common and important beliefs which are incorporated into belief systems around the world. For detailed descriptions of such systems, see the Manual on Socio-cultural Factors and the accompanying literature review, Asian Medical systems (Leslie 1976), Health and the Human Condition (Logan and Hunt 1978), Health, Culture and Community (Paul 1955), Modern Medicine and Medical Anthropology in the United States and Mexico Border Population (Velimirovic 1978), Community, Culture and Care (Brownlee 1978), and the journals Medical Anthropology and Social Science and Medicine.

The disease causation beliefs just described may be classified into two categories, personalistic and naturalistic (Foster and Anderson 1978:53).

1. "A personalistic system is one in which illness is believed to be caused by the active purposeful intervention of a sensate agent who may be a supernatural being (deity or god), a nonhuman being (such as a ghost, ancestor, or evil spirit) or a human being. The sick person literally is a victim, the object of agression or punishment directed specifically against him, for reasons that concern him alone."
2. "In naturalistic systems illness is explained in impersonal, systemic terms. Naturalistic systems conform above all to an equilibrium model" such as the hot and cold system described previously.

The two systems are not mutually exlusive. Often the personalistic etiology (causal sequence) will be used to explain some illnesses and the naturalistic to explain the others; or different groups within a country will subscribe to the different etiologies.

Both these etiologies pose problems for the Western-oriented health care worker. The personalistic is very different from the Western approach. Western-trained health professionals are unlikely to claim any supernatural powers, and so are unlikely to be regarded as effective diagnosticians in this etiology. The naturalistic also presents problems because of two factors: First, in this etiology the patient is responsible for diagnosing his own illness. The patient informs the health practitioner of the diagnosis, and expects him to prescribe therapeutic measures. The Western-trained doctor's attempt to diagnose the patient is not regarded as appropriate behavior. Second, the concept of health as an equilibrium between opposing forces (such as hot and cold) is often a part of this etiology. This concept, although it has recently been gaining greater acceptance in areas such as environmental health and ecology, is not generally part of Western health training. This also leads to difficulties in communication between the health practitioner and the client.

The preceding common beliefs about disease causation are important because these beliefs have accompanying systems for prevention, diagnosis and cure. While self-diagnosis and treatment occur in nearly all societies, the services of practitioners are also needed in many instances. Where strong indigenous

medical systems exist, there may be one or more types of indigenous practitioners. However, Western-oriented private practitioners may also be sensitive to indigenous beliefs, and may incorporate them into their practices. Sometimes, the distinctions between indigenous and Western-oriented private sector practioners becomes blurred, as will be seen in the following discussion of indigenous practitioners.

B. Indigenous and Western-Oriented Private Practitioner

Types of Practitioner

Figure 1 presents a typology of health care practitioners ranging from all adults in a society who may know a few simple cures to the highly trained and specialized Western-oriented or indigenous practitioner. While the most common types of practitioners are listed, there may be others not mentioned here in some societies. The figure moves from left to right in terms of complexity and training and time invested in healing, and from top to bottom in terms of pratitioner type, from lay to Western-oriented.

It should be noted that some practitioners bridge the gap between Western and indigenous medicine, using elements from both. While this can occur with nearly all practitioners, two examples where it nearly always occurs are the injectionist and the pharmacist. The injectionist uses Western technique to inject Western derived substances (such as vitamin B, penicillin, calcium and many others) in response to illnesses diagnosed by both indigenously diagnosed and Western-oriented practitioners. Thus penicillin may have been prescribed by an MD or a pharmacist for an infection, while calcium may be given to restore strength after an episode of nerves. The pharmacist also usually functions as far more than a dispenser of prescriptions. He is often sought for advice on diagnosis and treatment, and may prescribe a wide range of medicines, including ones that in some countries can only be prescribed by physicians. The pharmacist is an important potential resource in the private sector.

Figure 1: A Typology of Health Care Practitioners
Levels of Indigenous and Western-Oriented Medicine

Types of Practitioners	General Lay Medicine	Specialized Lay Medicine	Limited specialized practitioner self-taught or appenticed, probably part-time	Indigenous or Western-oriented practitioner usually trained by other practitioners
Lay	All Adults	One or two adults per extended family		
Indigenous		A few adults. usually older women or men	Herbalist Bonesetter Massager	Midwife, Shaman, witchdoctor, Spiritist, other curer
Mixed			Injectionist	Pharmacist
Western-oriented		"Quacks?"		Western trained nurse--midwife, MD, RN, DDS

Practitioner Roles

There appear to be some universals in curing roles which can serve as guidelines for assessment (Foster and Anderson (1978:104-115). These are:

1. Specialization; This tendency is well known in Western medicine, but it occurs in indigenous medicine as well. For example, there may be bonesetters, injectionists and herbalists in addition to shamans and midwives. In some cases, specialization may influence prestige in opposite way from the West, where the specialist is usually more highly regarded. In Thailand, for example, a specialist is someone who only knows about only one area, and thus has little knowledge. A generalist's knowledge is much broader and his prestige is greater.
2. Selection and Training: In some societies, as in the West, personal choice followed by long and rigorous training determines who becomes a healer. While some people are acknowledged to have more skill in a particular area (such as surgery) than others, superhuman beings are not seen as involved in particular selection. In contrast, in many indigenous systems, a divine "calling" is considered important or even essential for a healer. This may come about through something that occurred at birth (breech and caul births are often considered special), or something which happens in life. A common pattern is for someone to become very ill, and for the shaman or other curer to discover that the illness is a "summons" to become a healer, and can only be cured by the patients' commitment to

that role (Sharon 1978, Paul and Paul 1975). Usually an apprenticeship to another healer is then undertaken, although sometimes other powers undertake to teach the former patient. One study describes a midwife in Guatemala who was taught her profession by the spirits of dead midwives (Paul and Paul 1975).

3. Certification: This can range from the medical board examinations in Western societies to an iniation of new shamans by older shamans.
4. Professional Image: Healers have a special place in most cultures. Often they are respected and admired, sometimes they are feared, sometimes both. Their behavior and dress may be designed to enhance their image. Ritual objects, ranging from stethescopes to rattles are also associated with practitioners. In some societies deviant personality characterisitics may be associated with healers. "Often, indeed, personality characteristics that in Western society would be branded as dangerously deviant are recognized in non-Western societies as prerequisites for successful curing careers, and when these characteristics begin to manifest themselves at an early age in children, members of the group feel most fortunate" (Foster and Anderson (1978:110).
5. Expectation of Payment: This ranges from clearly defined fees set by both Western-oriented and indigenous practitioners to the feeling that the gift of healing comes from a divine being and it is to be shared free of cost. Many practitioners allow the patient to decide what to pay. Some are paid as long as patient is well, and payment is stopped if illness occurs. While fees charged by indigenous practitioners can be very high, in general, they are lower than those charged by Western-oriented private practitioners and sometimes lower than those charged by the public health sector.
6. Belief in powers: Every society has a few practitioners who know they cannot help a patient but lead the patient to believe they can. Most practitioners, however, both Western-oriented and indigenous, believe they are doing the best they can for their patients. They are acting in good faith. Both Western and indigenous practitioners may use placebos, but they tend to be used with the patient's best interests in mind. This is an important point, because Western-oriented practitioners and other observers sometimes consider indigenous practitioners "quacks" or "charlatans." The Western medical system may have more effective solutions to some problems, but a practitioner who is acting in good faith is not a charlatan.
7. Attitudes of the public: In most cultures medical practitioners are both feared and revered, admired and critized. Much of this is due to the power held and exercised by most medical practitioners. "In all societies, people fear, and hence dislike and distrust their fellows who exercise power, potential or real, over them. This is particularly true when the average man has only an imperfect understanding of the nature of this power" (Foster and Anderson 1978:114).

Patient-Practitioner Interactions

As can be seen from the above discussion, there are many similarities between Western-oriented and indigenous practitioners. However, there are also some important differences, which may influence a patient's choice of care. In the treatment process, the patient and the physician each has a set of expectations. When these differ, misunderstandings and conflicts may

develop. For example, a paper on the potential for the integration of indigenous and Western medicines in the U.S.-Mexico border area, presents the following discussion of provider-patient interactions.

> The Western-trained physician is educated to remain objective and "scientific" in his dealings with his patients. Part of the image he projects is that of a neutral, objective observer and diagnostician of human disorders--in short, a "professional." To the Mexican-American patient, who needs reassurance and warmth, touching is important during diagnosis and reflects caring. The Western attitude is incomprehensible and seems cold and impersonal, if not hostile. Furthermore, it reinforces already present fears of discrimination by Anglo-Americans.
>
> Efficiency is another characteristic that is highly prized by Western medicine and philosophy in general. The physician, faced with a heavy patient load and minimum funds, avoids lengthy discussions with his patients and gets quickly to the point of the visit. To the Mexican-American patients, illness is too serious and frightening to rush. The "proper" medical person makes some small conversation before getting down to business. The physician's lack of preliminary pleasantries or concern with the patient's own opinion of his illness is considered rude and does nothing to allay patient fears and prejudices.
>
> A common source of poor communication between patient and physician is attitude toward authority. The Western practitioner expects his patients to recognize his authority and feels it is his patient's responsibility to seek and follow his professional advice. The indigenous practitioner, however, does not dictate to his patient, but merely makes suggestions. To the Mexican-American, the physician's attitude is seen as authoritarian and presumptuous.
>
> Western medical philosophy emphasizes the individual and his responsibility for his own illness. Anglo-Americans commonly tke blame for having become sick. As discussed previously, Mexican disease theory includes a view of the individual as the victim of external forces. Nor is the individual free to make decisions on acceptance of treatment. Professional medical personnel expect the patient to make quick decisions and to accept the physician's advice. However, to the Mexican or Mexican-American patient and in the indigenous system, a practitioner's opinion may influence decision-making but will not constitute the final authority. Individuals do not act alone in situations as important as illness. Validation and support, both economic and social, of the sick role must come from the patient's family. Diagnosis and treatment suggested by the practitioner, be he or she Western or indigenous, will be discussed, evaluated, and accepted or rejected by the patient's family as a whole. Chiding or scolding the Mexican-American patient for his negligence or demanding on-the-spot medical decisions will only increase patient anxiety. (S. Scrimshaw and Burleigh 1978:37-38)

As mentioned previously, many Western-oriented private practitioners do not in fact understand and incorporate aspects of indigenous belief systems. For example, if a Latin-American woman tells a private practitioner she has "nerves", he is more likely to use this as an opening to get her to further describe her problem further rather than to say there is no such thing.

C. The Private Sector

As stated earlier, reliable information on the private subsector is almost nonexistent, although many rural health activities have occurred independently of planned national development. Many philanthropic and religious organizations have established hospitals and health centers in rural areas. Although permission to do so may have been sought, attempts to coordinate their activities with those of the national health activities have proven unsuccessful in most cases. Until recently, the private and indigenous subsectors have generally functioned independently of national health services. It is at this juncture that the private and the indigenous subsectors have their greatest similarity despite the fact that the private subsectors are usually oriented toward Western medicine. It should be stressed that private resources for health care can be found in both rural and urban areas, but the concentration of private wealth in urban centers means that private medical care plays a greater role in those places. It has been stated that it is the incompleteness and the deficiencies of the public medical care programs that permit a private sector to flourish (Roemer, 1963). An integrated and comprehensive system of medical care would doubtless reduce the private sector to much smaller proportions. Patients who were served adequately in a public system would not take recourse to private practitioners. However, the allocation of time and resources seem to be the determining factor for many urban and rural dwellers in deciding what type of practitioner to frequent for any or all diseases (Warren, 1974; Grollig, 1976).

The private market cannot be expected to allocate to health either the amount or the composition of resources that is best from a social perspective. For example, procedures which halt the spread of communicable diseases yield benefits to entire communities and, therefore, cannot be chosen properly by private individuals acting in their own interest. Often the private market mechanism will direct resources to these health expenditures that have an attractive financial payoff. Private corporations frequently undertake disease control before opening up new land for commercial plantation or mineral exploitation.

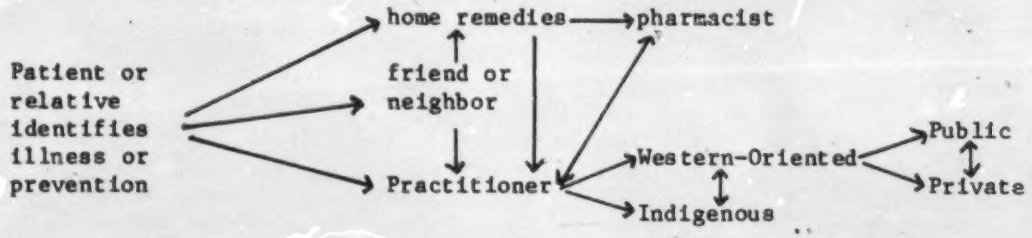
In programs to improve the general health of the bulk of the population, the private market mechanism undeniably operates but the distortions are very serious. Because of maldistribution of incomes in countries where average incomes are also very low, the health needs of the poor are not translated into effective demand. While the distortions caused by income inequality applies to all sectors, the consequences for health are particularly tragic.

Furthermore, concentrations of population have an adverse consequence on the distribution of health resources. Since urban centers are the focus of a cash economy, they attract a disproportionate number of persons who can afford to pay for part or all of their health care. Thus, the extent of urbanization is one of the factors influencing the extent to which a given country can sustain

private practice. There is a real danger that an increasing proportion of scarce medical, nursing, and other personnel (many of whom have been trained at government expense) will enter private practice. In this work, they may be led to pay more attention to curative care than to prevention and they will certainly provide services to fewer patients. Moreover, cities offer greatest opportunity for specialization, in which some physicians find the highest professional rewards. These opportunities may attract physicians to private practice in the cities even though the average financial rewards of such practice may be less than those available in the organized government services. The trend to urban private practice can deplete the organized government services, which force the acceleration of training programs. It can also force higher salaries in the organized government services, with the result that fewer personnel can be supported by a given budget (Abel-Smith 1967).

D. Health Decision-Making

Figure 2: Health Decision-Making Model



The first step in health decision-making is the decision that someone is ill or that preventive measures need to be taken. This decision may be made by the patient, or by a relative. Someone in the household, often the dominant woman, decides a problem exists. As shown in Figure 2, he or she may try some home remedies, may ask a friend or neighbor for advice, or may go to a pharmacist, any of several indigenous practitioners, any of several private Western-oriented practitioners, or the public health services. Commonly, individuals will go back and forth from one resource to another, using them sequentially or even in combination. Sometimes this is because they are seen as fulfilling different functions. The Western-oriented practioner can cure the symptoms of evil eye but the indigenous practitioner must deal with the cause. Sometimes indigenous practitioners encourage the use of Western medicine "this problem is for the doctor at the health center," sometimes they are in competition with it. Another reason for multiple use is that people feel one treatment is not working well enough and they want to try another, or people are unhappy with the reception they get with one practitioner. In one instance, a woman who was turned away from a hospital because she was not yet in labor, sought a midwife and asked for something "to hurry the baby up." Records kept for 30 families in one Guatemalan village showed frequent patterns of the use of five or more practitioners, ranging from the local health clinic to a private religious hospital to a private Western-oriented practitioner to the local injectionist and the local curer, all in the course of treatment of <u>one</u> illness episode in a young child. In the case of one family, an amount equal to the entire family income for one month ($30) was spent in a 40 day period, when the child's major underlying problem was malnutrition. The family went from practitioner to practitioner, desperately seeking a solution.

The multiple use of practitioners is a common element wherever more than one type is found. The significance of this for health sector planning is discussed in the next chapter.

CHAPTER III. THE POTENTIAL FOR INTEGRATION AND COMPLEMENTARITY IN INDIGENOUS AND WESTERN-ORIENTED HEALTH SYSTEMS

A. What is Integration?

In the past, "integration" has been a euphemism for teaching the indigenous practitioner minimal Western medicine, while trying to discourage him or her from continuing previous practices. This was often done without an evaluation of the relative merits of each aspect of both health systems. In a reversal of this trend, the current WHO program has modified this approach by outlining the following objectives:

1. To foster a realistic approach to traditional medicine in order to improve health care.
2. To evaluate traditional medicine in the light of modern science so as to maximize useful and effective practices and discourage harmful ones.
3. To promote the integration of proven valuable knowledge and skills in traditional and Western medicine (Bannerman 1977).

These objectives represent the important recognition that both medical systems may have something to offer each other and communicate a respect for all medical systems. However, there is a lack of detailed information on how to implement these objectives. The possibilities include:

1. Mutual exchange of information and techniques between medical systems in order to use the best possible techniques for each situation.
2. Combining healers from more than one system in a single facility.
3. Acceptance or encouragement of multiple use of healers.
4. Increased awareness on the part of both indigenous and Western practitioners of the social, religious and other contexts of health and illness in each other's cultural system as they relate to health.

For the most part, concepts of integration have tended toward a one-sided version of the first possibility, in order to extend the Western system to rural areas. Contributions of other systems to the Western system are now being considered. In practice, however, this alternative generally gives control to the Western system, a fact which may be acceptable in some cultures but not in others.

The second alternative has also been criticized as a co-option of the indigenous practitioner. Again, its viability is situational, and its practicality and acceptance will vary.

The third possibility may be hard for Western medical practitioners to accept, since it implies that indigenous practitioners need not always change and adopt some Western ways (although the three possibilities are by no means mutually exclusive). However, the rejection of indigenous practitioners who have not received some Western training as old-fashioned, ineffective, or dangerous tends to alienate both these practitioners and many patients. Such attitudes are not conducive to good relationships with health service users nor to high rates of health service utilization. While the assumption is that the two systems are incompatible, this is often not the case. A first step in the improvement of of understanding between indigenous and Western biomedicine is simply the acceptance of dual use. This means recognizing that culturally

important "causes" and treatments of illness may need to be dealt with by indigenous as well as Western means.

Increased respect for dual treatment and indigenous beliefs also means that indigenous practitioners may begin referring patients to Western practitioners. Sometimes this is done in the face of opposition, as is the case of Spiritists in New York. Traditional practitioners often know what symptom constellations different healing methods can treat more effectively, and they refer patients accordingly.

Which of these alternative or combination of alternatives is adopted in a given area depends on many factors, such as the numbers and types of existing Western-trained and indigenous practitioners, their knowledge of and respect for each other, the various cultures in the area, their health problems and concepts regarding health care, and the socioeconomic status of individuals in the community. The choice and implementation of alternatives is predicated in part on information that can and should be provided by researchers, planners and practitioners from both the Western and indigenous systems.

B. How to Approach Integration

Adaptation

Adaptation means incorporating Western health care ideas into the existing set of health beliefs in a society (Paul, 1955:4-5). The content of the indigenous system--what is proscribed (or prescribed) by tradition--is changed (Kirkby, 1973:8). This is happening in Guatemala, where substances classified as "fresco" ("cool" or "fresh") are considered beneficial to health. New foods and medicines introduced from the developed countries are frequently placed in this category thus encouraging their use. It has been suggested that adaptation become a deliberate process, with public health personnel changing their approach to "adapt their remedies to the people's conceptions and practices, rather than conflict with them" (Cosminsky, 1977:206).

Accomodation

Accomodation, which seems to be more prevalent, occurs when a number of alternative healing methods exist in one place. Western health care is simply accomodated in the system as one more alternative. In India, for example,

> ....though largely unrecognised by the allopaths (practitioners of Western medicine), a division of labour has been established which in a complicated way distributes and remits patients between the two systems (Djurfeldt and Lindberg, 1975:213).

Competition

In Ghana, which also has several different modes of health care, a similar division of labor is effected (Warren, 1978:73).

In most of the less developed countries today, Western health care competes with indigenous healing systems for patients. Indigenous medicine presently provides a large proportion of the health care because it is more accessible,

less expensive, and better adapted to the social milieu than is Western medicine (Ramalingaswami and Ramalingaswami, 1973:208). Another consideration is the persistence of traditional curers in their refusal to treat certain cases:

> Most indigenous practitioners are very competent in judging which patients they cannot cure. In that way they reduce their failures and increase their apparent therapeutic efficiency. The cases which they cannot treat are remitted to allopathic practitioners (i.e., Western health workers). The latter thus get more than their share of severe cases, which decreases the proportion of patients which they can cure, and consequently decreases their apparent efficiency in dealing with their patients. (Djurfeldt and Lindberg, 1975:212)

It has been proposed more than once that indigenous practitioners be deliberately integrated into the health care system. This would have advantages in that such practitioners are generally far more numerous than Western health workers, providing health care where no other form is available (Ramalingaswami and Ramalingaswami, 1973:208). They also supplement modern medicine in urban areas (McMichael, 1976:200), and they often have considerable practical knowledge (Djurfeldt and Lindberg, 1975:209).

Replacement

Another approach would be to induce the indigenous healers to abandon traditional methods for Western medicine (Kirkby, 1973:145). The advantage of this is that practitioners would be using what is presumably (though this may be somewhat biased) the most effective means of health care for many, but not all, problems. It might be very difficult to institute this change, however. It involves a major change in beliefs and practices on the part of the practitioner, who may be difficult to convince that his or her previous methods were useless and in fact, this is often not the case. Some traditional curers have invested a great deal of time in learning the indigenous methods; this would also make them reluctant to give up those practices. Patient demand might be an important factor working against this approach, since traditional methods have high apparent efficacy. Also, as long as patients retained the local beliefs about disease and expectations of providers, indigenous practitioners retrained in Western methods might not be accepted.

Addition

Another way of incorporating traditional healers into a system of modern health care would be by adding Western methods to their repertoire. This might maintain greater congruence between patient and practitioner, since the indigenous system would not be completley discarded; expectations of provider roles and disease etiologies would remain the same to some extent. Reconciling the local beliefs and practices with Western methods could be a problem for may types of indigenous curers, especially those etiologies whose beliefs and practices diverge most from Western ideas. Additionally, the practitioners might choose to blend the two approaches in ways which would result in low effectiveness.

In considering some of these approaches, the user of this manual is urged to see Introducing Culture Change by Arensburg and Niehoff (1971) and Communication of Innovations by Rodgers and Shoemaker (1971) for many valuable suggestions.

CHAPTER IV. METHODOLOGY FOR THE ASSESSMENT OF THE INDIGENOUS AND WESTERN-ORIENTED PRIVATE ASPECTS OF THE HEALTH SECTOR

A. The Need for Assessment

Probably the most critical aspect of planning is the need for adequate assessment techniques to determine what is happening, what trends have led to the present, and what the future might hold unless there are interventions (Blum, 1968). Assessment establishes the basis for planning strategy. A thorough assessment is essential for placing health sector problems and needs in some perspective. A health sector assessment is performed by systematically collecting data about the health service needs of a community, region, or national unit. It entails the identification of populations with service needs as a basis for determining whether these needs are being met.

At the broad planning level, assessment information (or data) may provide the basis for determining resouce requirements. Such data also may help determine the need for specific facilities, such as hospitals, clinics and dispensaries. At the program and for specific personnel levels, assessment data aid in national program planning. Knowledge of a community's health needs may allow program administrators to establish more realistic program goals, set priorities, allocate funds, plan new services, and restructure existing services. The data will also be important in assuring that proposed interventions correspond to the needs of the service area. It may also be possible to identify cultural, ethnic, or other barriers which could impede the delivery of health services to certain subpopulations within a community. Data on service needs and service utilization patterns also provide a baseline for evaluation of program effectiveness. As a result of this process, a picture emerges that could enable planners to weigh the overall situation and draw broad conclusions (Blum, 1974).

B. Methods for Assessment

Use of Existing Knowledge and Resources

The first step in any assessment of the type described here should be the exploration of existing knowledge and resources. This should range from searching out previous research relevant to the topic to talking with knowledgeable individuals. Unfortunately, this task is complicated by the fact that some researchers from outside a country do not return the results to that country. Often, the results of previous research <u>does</u> exist within a country, but it is difficult to find. It is suggested that a literature search within the county (and in major international journals if possible) be conducted, and that relevant individuals in the management, health and social sciences within the country be approached and queried about their knowledge of existing information.

Knowledgeable individuals may include health planners, health professionals and indigenous and private practitioners. The latter two categories should not be omitted because frequently health officials may not be in contact with them and so will present an incomplete picture of the situation.

Participant Observation

Participant observation is the process of getting the "feel" of a situation as well as a detailed and complex methodology of itself.

The methodology is well described by Pelto and Pelto in Anthropological Research: The Structure of Inquiry (1978) and by Spradley in The Ethnographic Interview (1979).

Whatever else is done in the course of an assessment, it is strongly suggested that a small amount of participant observation be conducted by getting out into rural areas, villages, urban slums and the like and talking with people ranging from village political leaders to indigenous and private practitioners, to private individuals about their health, beliefs, their perceived health needs, and their health seeking behavior. Although some information will inevitably be withheld, a great deal more will emerge, and the experience will provide a sense of the situation which cannot be obtained any other way.

This approach has also been called the "community impressions approach" by Siegel and his colleagues (1977). They suggest combining impressions about the health needs from key individuals living or working in the community, and then verifying the information gathered with those groups in the community identified as having the greatest health needs (Siegel, et. al., 1977). The approach has three major steps:

(1) key person interviews
(2) social indicators data review; and
(3) community forums targeted on underserved groups.

Interviews are conducted with 10 to 15 individuals who either work or live in the community including village elders and traditional elites. They can offer a wide range of impressions about the private and the indigenous subsectors and the health needs of different groups in the community. Health purveyors from the private, indigenous and public health subsectors are also interviewed. The interviews should be conducted with a list of questions about private and indigenous health and related services in the community and some demograhic characteristics of the population and a map of the community under study. A demographic and service picture of the community should emerge. Data required in the social indicators approach should be obtained to supplement or verify information received in the interviews. Additional verification of the resulting data could be acquired in a series of community forums or meetings that should include those groups identified in the previous steps as having specific health needs that are not being fulfilled under the existing conditions. The intent of the forums should be to elicit views from as many people as possible about the health needs in the community and to identify those who are interested in doing something about those needs.

As pointed out by its proponents, the community impressions approach has its advantages and disadvantages. It can be carried out inexpensively and it permits the inclusion of a variety of variables that could be regarded both as factual and impressionistic about the health needs of a community.

Social Indicators

The social indicators approach consists of estimating need on the basis of available descriptive public statistics about a community. These data are often intrinsically helpful when viewed in isolation; however, their greatest utility is derived when assessed in the context of the other more significant sources of information (Siegel, et al, 1977). The underlying assumption in this approach is that variables such as population density are related to the incidence of health problems. The major use of such data in a private or indigenous subsector assessment would be to identify specific health and other human service needs in a community. Development of viable indicators depends on three conditions:

(1) The validity (accuracy) and reliability (replicability) of the descriptive information.
(2) The logic and statistical appropriateness of procedures used to derive the social indicators.
(3) The subjective sense for the community that is developed through other sources of information about the community (Siegel). The major disadvantage of this approach is the lack of empirical evidence on the strength of these relationships.

Community Surveys

1. Advantages

Surveys allow for the collection of data that are not always on hand. Surveys can be used to determine the demand for service and available resources in the private and indigenous health subsectors and to obtain community residents and agency views on health beliefs, health problems and service needs. Because of the importance of understanding the number and types of demands for service and the capacity to respond to the demands in a health sector assessment, gathering such information on the private and the indigenous subsectors should be an early activity. Community residents' views would include a random sample of people living within the geographically defined service area. The sample could be stratified by such variables as age, ethnicity, socioeconomic status, occupation and leadership. Surveys can also be used in conjunction with the social indicators approach for a broader assessment of a community's health needs.

A major advantage of the community survey approach, compared with other available approaches to the assessment of private and indigenous health needs, is the breadth of information that can be collected. No other method is capable of producing this amount of information. Moreover, some information useful for program planning such as that relating to attitudinal barriers to service utilization--can be obtained only by means of a survey.

Another advantage of the methodology is its potential for obtaining accurate information. The use of probability sampling methods ensures that no one subpopulation will make a disproportionate input (as is often the case in the community forum approach). An important limitation, however, may lie with the validity and reliability of the data collection instruments which require extensive instrument development and testing.

Limitations

Surveys provide quantitative data which are useful for statistical analysis and the description of a large population, but in depth qualitative data are essential to the understanding and interpretation of the quantitative data, particularly when it comes to the dynamics of human behavior. The difference between what people tell an interviewer they do and why they do it, and observed behavior and apparent motivation can be very great. Ideally, qualitative research such as participant observation should preceed the quantitative, so that the survey is designed to fit local variables of importance, vocabulary and wording. The qualitative work also helps establish which topics can be meaningfully covered in a formal interview format. In nearly every culture, there are some subjects which are not openly discussed. Chen and Murray (1976) present an excellent discussion of this based on research in Haiti which should be consulted by anyone planning survey research in Latin America.

If the user of this manual does not have the time or the resources to consider a survey, it is suggested that the first three approaches described here be utilized to gather information on the variables listed further on in this manual. If the resources are available, the person or persons conducting the health assessment should either be trained in survey methodology or contract the research to the local group with skill and experience in survey work. Conducting a survey is a major proposition which should not be undertaken lightly, and much information can be gleaned from the other methods described here. If a survey will be conducted, the following paragraphs may assist in its planning.

Questionnaire Development

It cannot be emphasized too strongly that the construction of interview schedules requires considerable fore-knowledge about cultural patterns and family life styles of the prticular communities studied. Thus a preliminary period of informal interviewing and open-ended observational field work is strongly recommended before interview schedules are drawn up.
Also, pretesting the language and format of the interview schedule is essential. The wording of questions must coincide with the language usuage of the community so that local people will understand the questions' meanings, and will not be affronted by strange language usage. For example, researchers in Latin America have developed questions in "proper" Spanish, only to find that people in local communities could not understand the questions effectively until they were re-shaped in the local idiom.

It is also important to understand what the question means to the respondent. For example, a mother may say that her baby is currently "well," but the local definition of a well child may include a child with parasites ("all children have worms"), edema ("a plump baby is healthy") and so on. A Western health program's definitions of health and illness and the mother's may be quite different.

Most of the items in an instrument could be taken from existing instruments. Although the reliability and validity testing may have varied, all have had prior field application, which shortens and simplifies the pretesting of instruments. Caution is necessary, however, in abstracting or using only part

of previously validated batteries of items, since the item validities are sometimes not maintained when they are used out of the context of the total original instrument. In a new context, individual items an interact in unknown and possible undesirable ways; therefore, some validity and reliability pretesting of the planned instruments is necessary.

An ideal survey instrument would have the following features:

- It would be economically and easily administered by lay persons.
- It would be brief and highly acceptable to the population being surveyed.
- It would be sensitive to a wide variety of health related beliefs and behaviors.

Sampling

As a general approach, multistage cluster sampling is recommended. A cluster sample is one in which the population is divided into groups (i.e. clusters), and a sample of these groups is selected. In an urban area, for example, city blocks may be used as clusters or geographical units in a rural area. Every block in the city should be identified, and appropriate number of blocks should be sampled systematically (i.e., in a way that ensures that the blocks are spread out over the entire area of interest). For each selected block, the households on that block should be listed, and a random sample of them should be selected. First selecting blocks and then households requires two stages; this procedure is known as multistage sampling. Further, as discussed below, individuals are then sampled within households.

Multistage cluster sampling has certain trade-offs. On the positive side, cluster sampling is less expensive than the alternative of probability sampling because the process of preparing the sampling frame (i.e., the list of sampling units from which a survey sample is selected) is greatly simplified. It is much easier to list the households in a sample of city blocks or rural geographical unit than to list all the households in either site. Additionally, travel time and expense is reduced since the interviews are grouped rathe. than spread throughout the site. On the negative side, statistical analysis is more complicated. Variance estimating procedures for computing confidence limits about sample statistics are much more complicated than those used for simple ra dom sampling.

Because of the complexities of designing a specific sampling plan, it strongly recommended that the survey office have a sampling expert on its staff, or engage the services of a sampling consultant. Moreover, professional assistance can be highly cost-effective. Significant savings can result from reduced interviewer travel time and simplified data analysis.

The survey population consists of all individuals who are eligible for health services in the geographic area under investigation. Most reside in households and could be interviewed there. Within households, both the dominant male and female should be interviewed. Alternatively, an adult should be selected at random and interviewed.

A survey should also be done of both indigenous and Western-oriented providers in the area. In some cases, these individuals may have to be located by asking people to identify them, thus establishing a network.

Sample Size

The number of households or individuals required in the survey is related to the size and probability of error that can be tolerated. If the effects of clustering in the sample are not too severe, a sample of approximately 400 households would provide estimates of population proportions that are within plus or minus five percentage points of the correct value with probability of 0.95. Estimating formulas and tables are available for determining the appropriate sample size for varying levels of precision. Whatever sample size is needed to achieve the desired precision, that same sample size will be required to achieve the same precision when sampling from a subpopulation. Thus, for example, if rural poor constitute 15% of the target population and a high (i.e., 0.95) probability of being within plus or minus five percentage points in estimating a proportion is needed for the rural poor alone, then the sample must contain approximately 400 rural poor households. Without a special means of overselecting the rural poor, the total sample size required would be 400/0.15, or 2,667.

The guidance of a sampling expert is especially required for sample size determination. In each application of the survey methodology, a number of factors must be taken into account in determining sample size--e.g., the proportion of each target group in the general population, the overlap in membership among target groups, and the heterogeneity of the clusters.

Interviewer Selection and Training

To minimize the need for extensive training of interviewers, candidates should be selected who:

1. Meet the minimum education and training requirements. Interviewers recruited for this survey should be college graduates; ideally, they should have degrees in the social or behavioral sciences and know the local language.
2. Can be recruited in reasonable numbers.
3. Can be compensated at rates compatible with reasonable budgetary constraints.
4. Can carry out their duties during evenings and weekends as well as usual working days and hours.

Other criteria for successful performance as an interviewer include honesty, attention to detail, and a personality that is neither overly agressive nor over social. Such traits are best assessed in an applicant in a comprehensive, fact-to-face screening interview.

In addition, it may be advisable to recruit community residents as interviewers. Because the respondent is being questioned by someone from the community rather than an outsider, it may be easier to establish rapport, gain the respondent's trust, and consequently obtain more accurate answers, especially with sensitive questioning of the kind employed in this area.

The interviewer training program should be conducted immediately before actual field work.

The training program should encompass the following five areas:
(1.) Sampling frame listing procedures
(2.) General interviewing procedures
(3.) Use of the informant questionnaire
(4.) Use of the interview guide, and
(5.) Administrative procedures.

To prepare the inteviewers for actually conducting the interviews, the training program must also address general interviewing techniques. These techniques include how to make the initial contact with the respondents who are suspicious or reluctant They also include how to ask questions, how to probe, and how to record responses.

After completion of format instruction in the use of the instruments, the trainees should engage in role playing exercises in which they administer the interviews to each other. Before going into the field, the interview trainee should witness several actual interviews, preferably outside of the study area to: (1) familiarize themselves with the questionnaire in a working situation, (2) obtain feedback on the adequacy of their performance so that areas of weakness can be strengthened, and (3) further pretest the instrument.

The training program must also cover administrative procedures. These procedures include how and to whom to communicate about problems encountered in the field, and how and when to turn in completed work.

Because interviewers often forget some of the important concepts covered in the intitial training program, become careless in following procedures, and become perfunctory in introducing the survey and asking questions, the survey office should establish periodic review classes during the progress of the survey.

C. Variables to be Studied in the Assessment

The following lists of variables represent the ideal. In reality, it may not be possible to obtain information in all areas. Most of the information may be obtained at at least one level by all the methods described here. The more methods that are used, the more precise the assessment.

1. Community
   Type (rural, urban, etc.)
   Size
   Ethnic composition
   Economic levels
   Age composition
   Sex composition
   Major health problems
   Major types of health services
      Public
      Private
      Indigenous
   Numbers of services or practitioners available, their locations (distribution), and training

2. Community leaders
   All the items listed under individuals, plus the following:
      Perception of community health problems
      Perception of community health needs
         Infrastructure (water, etc.)
         Public clinics
         Private Practitioners
         Indigenous practitioners
   Assessment of the utility of current public clinics, private practitioners, and indigenous practitioners.

3. Individuals
   Age
   Sex
   Sexual union status
   Household size
   Household water supply
   Household system for disposal of human waste
   Estimate of economic status
   Definition of health
      For adults of each sex
      For children
   Definition of illness
      For adults of each sex
      For children
   Who decides when someone is ill?
   Taking 2-3 common illnesses, elicit the following steps in treatment.
      Who is seen
      When in the course of the illness
      Treatment prescribed
      Cost
   (Keep in mind that more than one practitioner may be available)

   What causes illnesses (use specific illnesses as an example)

   Ask the individual to describe and assess public health clinics, private Western-oriented practitioners, and indigenous practitioners.

Find out if anyone in the household has been ill in the last week or two. Get a detailed history of the illness, its treatment, the practitioner(s) involved, and the cost.

Percent of income spent on health care

4. Practitioners (Indigenous and Private)
   Type of practitioner
   Training
   Years in practice
   Clientele
      Age
      Sex
      Types of problems
   Fees
   Description of self
      Why a healer?
      Why practices in this community?
      Statement of community perception of him or her.
   View of public sector
   View of Western medicine and on indigenous medicine in that society
   Awareness and opinion of multiple use of practitioners

D. Data Analysis and Summary

The data analysis and summary will usually be both descriptive and analytical. Findings based on all the various techniques used should be summarized and discussed (descriptive). If survey techniques have been used, then statistical analysis can be used to look at correlations and associations (analytical). For example, questions can be asked like "What does educational level have to do with the type of health practitioner an individual prefers?" or "People say they prefer indigenous practitioners, but in actual fact do they make significantly more use of indigenous practitioners than Western ones?" Survey data analysis requires the use of a computer, and it is essential that an experienced statistician be involved.

The list below suggests ways of summarizing that information collected on the basis of this manual.

Practitioners

1. Types

Some variety of typology should be constructed that will allow an identification of the different types of private or indigenous practitioners that are available within a predetermined area or region. They may be differentiated by philosophical world view (a folk healer versus a physician), by training or specialization (i.e., whether received in a formal institution or apprenticeship), and by treatment (i.e., bone setter, herbalist, or physician). (See p. 23 of this Manual).

2. Numbers

An overview on the order of magnitude of the number of different types of practitioners, as compared to absolute numbers, that are practicing within the area.

3. Distribution

Understanding where the various types of practitioners are located is very important. This can best be determined by mapping the area under investigation. As shall be shown, this step is necessary to correlate types of clientele serviced by the practitioners and the client's general socio-economic conditions.

4. Training

The type of training received by the practitioners, skills maintenance, access to new information, and continuing education are the immediate concerns.

5. Attitudes

Attitudes toward their own and other healing systems, towards the integration of healing systems, and toward healing itself.

Clientele

1. Size

Information on clientele is quite essential as the number of inhabitants and their age-distribution in part determines the extent and nature of the medical attention with which a community must be provided. The pathway of a young population will be different from that of a community in which ages of the inhabitants is higher and which will therefore require medical attention of a different kind.

The population of the region should be reported since it represents the potential size of the clientele. One of the approaches previously mentioned should be utilized to determine how many patients (the actual clientele) go to what type of practitioners and for what type of services. It should be expected that many patients may utilize a variety of indigenous and private practitioners for a single particular illness.

2. Distribution

Another important characteristic of the population of a local planning area is its geographic distribution within the area, including the number and size of the population centers. The provision of services in predominently rural areas calls for a different approach than that required in areas that are principally urban in character.

The distribution of clients should be shown by mapping the area as was done with the distribution of the practitioners. In some cases it should be expected that a majority of the clients of the indigenous practitioners would be located in marginal areas and those of the private practitioners in more affluent areas. This could be correlated to the type of practitioner. Too often the privileged and well to do, living in large towns and cities, enjoy access to all the complex technology and lifesaving apparatus of Western medicine (Mahler 1977). But in some affluent areas along with the development of a stronger sense of national or ethnic identity, a concomitant respect for national or ethnic medical traditions has developed. Hence, this trend may be reflected in the distribution and utilization patterns of the clientele.

3. Utilization Patterns

This step would establish a determination of how the clientele utilizes the private or indigenous practitioners. The pattern could be approached by specific illness. In many areas the practitioner of Western medicine are most commonly utilized for infectious diseases and trauma while the indigenous practitioners are utilized for the more psychosomatic illnesses. Dual and multiple utilizations should also be observed. The major determinants for utilization patterns would be access to services, cost, acceptability, and perceived effectiveness.

4. Socio-economic Status

Indicators such as last year attended in school, occupation, and monthly income would assist in completing the assessment of the clientele and to

distinguish which segments of the clientele would utilize what type of practitioner.

5. Attitudes

Attitudes toward health and illness, various health systems, and steps to take to treat illness.

Practitioners

1. Type

There are basically three types of institutions of which the assessor should be aware:

- Reproductive--These would be the institutions which train more practitioners in the same art. They could be as formal as Western-type medical school or as informal as an apprenticeship training situation.

- Delivery--The sites of where the care is given should be reported. Both types of practitioners make house calls as a matter of course and may not necessarily have a regular facility for practice.

- Advanced care facility--The primary/secondary/tertiary model for the private practitioners may not apply to the indigenous practitioners although they, too, could have rather intricate levels of care. The labeling of the degree of severity of an illness by the particular type of practitioner should be considered here, too.

2. Number

A reporting of the different types of consultation officers and types of institutions within the defined geographic area would be necessary.

3. Distribution

The regional map from the previous steps could also be utilized to pinpoint distribution of the institutions and how they relate to the distribution of the clientele and practitioners.

4. Relationship to Clientele

How is the patient admitted into the institution? The barriers to admissions are more pronounced when dealing with the Western-type health care subsector. The pattern of the indigenous practitioner should be delineated.

5. Relationship between Types of Institutions

Do the indigenous and Western-trained practitioners work together at the institutional level? Are clients referred from one subsector to the other? Are any resources shared? Are there antagonisms between the types of practitioners? Conceivably, there could be no relationship at all.

Expenditures of all Practitioners and Institutions

When the total amount of money flowing to practitioners and institutions is known, it would be important to trace their expenditures. Perhaps a percentage of the funds could be recycled in the region through the purchase of equipment and supplies, rental of facilities, and hiring employees. Perhaps important equipment and supplies from outside the region or abroad could create a net loss.

Legal Status

1. Legislative

In many countries there may be a number of statutes regarding what can or cannot be done to a patient by a particular type of practitioner. In some countries, certain types of indigenous practitioners are illegal or, in others, private practitioners are forbidden. Furthermore, these tend to be legislations that require private firms with employees of a certain number to provide a limited amount of health care. This type of information tends to be easily obtained at the central ministry of health.

2. Custom or Common Law Status

Not all laws are enforced all the time nor are they enforced equally. Quite often these will be a generally accepted understanding among authorities and between authorities and practitioners about what can and cannot be done without legal interventions. In many countries where private practices are illegal, they have been permitted to develop without tremendous interference. In some cases they have actually been encouraged to try to meet some of the demands on the public subsector. Where legislation has been passed against indigenous practitioners, it does not appear to have succeeded in causing them to cease practice as long as there is popular demand for their services. An understanding of the reasons for lack of enforcement should be understood. It could require some insight into the interplay between political, economic, and sociocultural variables.

Relations between the Private and Public Practitioners of Western Scientific Medicine and Indigenous Practitioners

1. Functional Description

A functional description of the relations between the practitioners could be of great utility. It may be quite common for the practitioners of Western scientific medicine to denounce and deride the indigenous practitioners or to utilize them in one form or another. The relations could be as follows:

- No Relationship--This could often be the case where the established Western scientific practitioners would not acknowledge the existence of any practitioners. However, the indigenous subsector almost always would have to acknowledge the practitioners of the other subsector. This situation would probably be the case in countries where the indigenous subsector is informal.

- Formal or Informal Relationship--The practitioners of one subsector could refer clients to the other, exchange information, and occasionally share resources. This situation would probably be the case in countries where the indigenous subsector is more formal.

Dynamics of Change

Social institutions are never static either within themselves or between themselves. Health care institutions are no exception. It should not be uncommon at all to discover alterations or shifts in the dynamics of relations between and among public and private practitioners of Western scientific medicine and the various indigenous practitioners. In attempting to remove the vestiges of a colonialist or imperialist past, nationalist or political movements could frequently influence health care institutions. In some cases, the dynamics of change could be manifested by increasing the legal and social status of the indigenous practitioners and, hence, increasing their responsibilities in some proportion of those of the public and private practitioners.

1. Relations between the Subsectors as Seen by Clients

There should be some attempt to discover the importance that clients attached to each of the subsectors available to them. As stated previously, there could be patterns of multiple utilizations. The assessor should relate the dynamics of utilization patterns from the perspective of the client. Some outstanding variables could be:

a. Ethnicity and Ethnic Identity

Ethnic group identity could deny the availability of one form of health care to a particular person. Similarly, the emergence of this identity could make particular type of indigenous practices more appealing.

b. Personal Experience

Previous experience with one subsector or the other could influence a client's choice. If administrative difficulties are encountered in gaining admission to a hospital, a client may not be favorably inclined towards utilizing that alternative in the future even though other variables would indicate such predisposition.

c. Special or Constituent Interest Private Providers

In addition to private practitioners of Western medicine, the private subsector could include but not be limited to health services offered by religious, benevolent, charitable, voluntary, philanthrop organizations, political parties or movements, labor unions, and national and multinational corporations. There could be some correlation between the goals of the providers and the constituency served. The type of information gathered in the previous steps for assessing the private and the indigenous providers could likewise be applied for the special interest private providers.

CHAPTER V. SUMMARY AND CONCLUSIONS

This manual has described the basis for including both indigenous and private practitioners in a health sector assessment, including the nature and importance of culture-specific beliefs about health and illness and the shortage of Western medical services, especially in rural and poor areas of developing countries. Methods for assessing the importance, the presence and the acitivities of both indigenous and Western-oriented private practitioners were also presented, as were methods for assessing the use of health providers and the health belief systems of the population at large.

There is little doubt that private practitioners, and particularly, indigenous practitioners must be incorporated into the network of health care providers if there is to be any hope at all of providing the rudiments of health services to all by the year 2,000, a major goal of United Nations and other international agencies (Bannerman 1977, Kleinman 1978). Without the help of such practitioners, many individuals and many regions will remain inaccessible. It is hoped that this manual will contribute to the effort to incorporate private Western-oriented and indigenous practitioners into the health networks of developing nations.

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